

FOR OFFICE USE ONLY
Name/Dept/Loc.
Acct#/Pay Mode
Initial Premium

**City of Tempe**  
GL 36063-5

**EMPLOYEE**  
Portable Term Life Enrollment Form

*How to apply:* Employees should use this form to apply for Portable Term life coverage. You must also complete and sign the Proof of Good Health form if you are applying for more than the Simplified Issue coverage amount of \$120,000; you answer "yes" to question '1' below; you are applying outside of an employer-defined Portable Life enrollment period; or the group participation requirements are not met.

**TELL US ABOUT YOURSELF** - *Print clearly in dark ink and return as instructed.*

Your Name ( <i>last, first, middle</i> )			Date of Birth ( <i>month, day, year</i> )		<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Hire / /
Annual Salary	Social Security #	Employee I.D. Number	Home Phone ( )		Work Phone ( )	
Residence Address		City	State	Zip		
Your Beneficiary ( <i>last, first, middle</i> )				Relationship		
Beneficiary's Address ( <i>street, city, state, zip code</i> )				Beneficiary's Phone Number ( )		
1. Have you ever had or been treated for heart trouble, stroke, diabetes, cancer, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), disorders of the immune system or tested positive for antibodies to the HIV virus? <i>If you answered YES to this question, you must also complete the Proof of Good Health form.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No						

**AMOUNT OF COVERAGE REQUESTED** - *Complete Option A or Option B below.*

(Minimum amount available is \$20,000; maximum amount available is \$500,000.)

<b>Option A</b> <input type="checkbox"/> I am applying for Portable Term life coverage in the amount of: \$_____ ( <i>\$10,000 increments</i> ) <b>OR</b>
<b>Option B</b> <input type="checkbox"/> I currently have Portable Term life coverage in the amount of: \$_____ I want to apply for <i>additional</i> Portable Term life coverage in the amount of: \$_____ <b>TOTAL AMOUNT OF COVERAGE:</b> \$_____ ( <i>Includes current amount and additional amount requested</i> ) (\$10,000 increments)

**OPTIONAL COVERAGE** - *Check to apply.*

<input type="checkbox"/> I am applying for Children's coverage in the amount of: <input type="checkbox"/> \$10,000 or <input type="checkbox"/> \$5,000 <ul style="list-style-type: none"> <li>• Either you or your spouse can apply for this coverage, but not both.</li> <li>• Coverage is limited to 10% of elected amount for children 14 days through 6 months.</li> <li>• This coverage is guaranteed if you're applying for coverage on yourself for the first time and your coverage is approved. If not applying for the first time, please contact the benefits office for a children's application.</li> </ul>
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*Please read and sign the back side of the form.*

## READ THIS INFORMATION CAREFULLY, THEN SIGN AND DATE BELOW

- To the best of my knowledge and belief, the information I've provided on this form is complete and correct.
- **I understand that any person who knowingly and with intent to defraud, submits an application for insurance containing any materially false or misleading information, commits a fraudulent act which is a crime.**
- I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life.
- I understand my coverage begins on the "effective date" assigned by ReliaStar Life, provided I am actively at work. I also understand that evidence of good health may be required for coverage to begin.

### **Authorization and Acknowledgment:**

For claim purposes, I give my permission to: Any physician or other medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsurance company, Medical Information Bureau, Inc.(MIB), employer or any other organization to give ReliaStar Life Insurance Company (ReliaStar Life), or its authorized representative acting on its behalf, **ALL INFORMATION** on my behalf (except as limited below), including findings on medical care, psychiatric or psychological care or examination, surgery or non-medical information as they apply to any person who is to be covered.

I give my permission to ReliaStar Life to get any and all such information for the purposes described in this form. I specifically consent to the redisclosure of such information as set forth in this form. I know that my medical records, including any alcohol or drug abuse information, may be protected by Federal Regulations -- 42 CFR Part 2. I may revoke this authorization as it applies to any information protected by 42 CFR Part 2 at any time, but not to the extent action has been taken in reliance on it.

I understand all or part of the information obtained by this authorization may be communicated between ReliaStar Life and its affiliates and may be sent to MIB. This information may be made available to any ReliaStar Life affiliate, reinsurer, employee, or contractor who processes transactions that concern any coverage I may have requested or have with ReliaStar Life or its affiliates.

I understand that my additional written consent will be required before any information described above is given, sold, transferred, or, in any way, relayed to another party not previously specified (unless otherwise provided by law). My additional consent must be provided on a form that states the new use of the information or why another party needs it.

I know that I have the right to get a copy of this form. A photocopy of this form will be as valid as the original. As it relates to the incontestability clause, this form will be valid for 30 months from the date shown below or for two years from the date coverage is made effective, whichever is earlier.

*Payroll deduction authorization:* I authorize my employer to deduct from my wages the premium for the above coverage.

<b>Employee's Signature:</b>	<b>Date Signed:</b>
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